		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027367

Facility Name: FAIR ACRES NURSING HOME

Address: 514 EAST JACKSON STREET (Number) DUQUOIN (City) 62832 (Zip Code)

County: PERRY

Telephone Number: (61) 542-4731 **Fax #** (618)542-4732

IDPA ID Number: 371119686001

Date of Initial License for Current Owners: 10/10/82

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618)549-8331

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	29	Skilled (SNF)	29	10,585	1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,425	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		3,572	688	4,260	8
9	SNF/PED					9
10	ICF	14,415	5,138		19,553	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,415	8,710	688	23,813	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.16%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
OUTPATIENT THERAPY

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 658

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	102,982	5,126	6,029	114,137		114,137		114,137			1
2	Food Purchase		76,073		76,073	2,760	893	(284)	609			2
3	Housekeeping	59,207	5,623		64,830	954	65,784		65,784			3
4	Laundry	38,243	5,487		43,730		43,730		43,730			4
5	Heat and Other Utilities			55,247	55,247	320	55,567		55,567			5
6	Maintenance	24,393	15,540	15,735	55,668		55,668		55,668			6
7	Other (specify):*											7
8	**TOTAL General Services**	224,825	107,849	77,011	409,685	4,034	335,779	(284)	335,495			8
	B. Health Care and Programs											
9	Medical Director			900	900		900		900			9
10	Nursing and Medical Records	612,791	22,446	58,076	693,313	(2,760)	690,553		690,553			10
10a	Therapy	17,064		7,958	25,022		25,022		25,022			10a
11	Activities	24,960	1,680	2,160	28,800		28,800		28,800			11
12	Social Services	20,946		2,160	23,106		23,106		23,106			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	675,761	24,126	71,254	771,141	(2,760)	768,381		768,381			16
	C. General Administration											
17	Administrative	43,469			43,469	42,807	86,276		86,276			17
18	Directors Fees											18
19	Professional Services			140,158	140,158	(77,060)	63,098	(58,505)	4,593			19
20	Dues, Fees, Subscriptions & Promotions			7,788	7,788	110	7,898	(1,687)	6,211			20
21	Clerical & General Office Expenses	21,291	6,592	4,760	32,643	18,991	51,634	(250)	51,384			21
22	Employee Benefits & Payroll Taxes			140,788	140,788	6,232	147,020		147,020			22
23	Inservice Training & Education			853	853		853		853			23
24	Travel and Seminar			2,538	2,538	145	2,683		2,683			24
25	Other Admin. Staff Transportation					1,184	1,184		1,184			25
26	Insurance-Prop.Liab.Malpractice			6,263	6,263	764	7,027		7,027			26
27	Other (specify):*											27
28	**TOTAL General Administration**	64,760	6,592	303,148	374,500	(6,827)	367,673	(60,442)	307,231			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	965,346	138,567	451,413	1,555,326	(5,553)	1,471,833	(60,726)	1,411,107			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIR ACRES NURSING HOME #0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			25,098	25,098	1,989	27,087	3,848	30,935			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							14,204	14,204			33
34	Rent-Facility & Grounds			222,000	222,000	3,564	225,564	(222,000)	3,564			34
35	Rent-Equipment & Vehicles			171	171		171		171			35
36	Other (specify):*											36
37	**TOTAL Ownership**			247,269	247,269	5,553	252,822	(203,948)	48,874			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,310	46,783	73,093		73,093		73,093			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		26,310	87,409	113,719		113,719		113,719			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	965,346	164,877	786,091	1,916,314		1,838,374	(264,674)	1,573,700			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,393)	30		9
10	Interest and Other Investment Income	(3,032)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,432)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(455)	20		28
29	Other-Attach Schedule SEE PG 5A	200			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,646)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(253,028)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (253,028)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (264,674)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIR ACRES NURSING HOME

ID# 0027367

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 SCHEDULE VI	$		1
2	2ND YEAR OF IDPH LICENSE FEE PAID IN 1999	200	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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29				29
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40				40
41				41
42				42
43				43
44				44
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59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	200		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(284)	0	0	0	0	0	0	0	0	0	0	(284)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(284)	0	0	0	0	0	0	0	0	0	0	(284)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(58,505)	0	0	0	0	0	0	0	0	0	(58,505)	19
20	Fees, Subscriptions & Promotions	(1,687)	0	0	0	0	0	0	0	0	0	0	(1,687)	20
21	Clerical & General Office Expenses	(250)	0	0	0	0	0	0	0	0	0	0	(250)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,937)	(58,505)	0	0	0	0	0	0	0	0	0	(60,442)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,221)	(58,505)	0	0	0	0	0	0	0	0	0	(60,726)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,393)	10,241	0	0	0	0	0	0	0	0	0	3,848	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,032)	3,032	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	14,204	0	0	0	0	0	0	0	0	0	14,204	33
34	Rent-Facility & Grounds	0	(222,000)	0	0	0	0	0	0	0	0	0	(222,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,425)	(194,523)	0	0	0	0	0	0	0	0	0	(203,948)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,646)	(253,028)	0	0	0	0	0	0	0	0	0	(264,674)	45

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		Senior Manor Nursing Center	Sparta	Twin Willows Land Tr	DuQuoin	Real Estate Rental
		Freeburg Care Center	Freeburg	Jamestown Mgmt Corp	Carbondale	Management
		Canterbury Manor Nursing Center	Waterloo			
		Fairview Nursing Center	DuQuoin			
		Three Springs Lodge	Chester			
		Pope County Care Center	Golconda			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 222,000	Twin Willows Land Trust		$	$ (222,000)	1
2	V	32	Interest Expense		Twin Willows Land Trust		5,393	5,393	2
3	V	30	Depreciation		Twin Willows Land Trust		10,241	10,241	3
4	V	33	Real Estate Taxes		Twin Willows Land Trust		14,204	14,204	4
5	V	32	Interest Income		Twin Willows Land Trust		(2,361)	(2,361)	5
6	V	19	Jamestown Mgmt Corp Fee	135,738	Jamestown Management Corp		77,233	(58,505)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 357,738			$ 104,710	$ * (253,028)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	*****OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO COST REPORT*****							*****	$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JAMESTOWN MANAGEMENT CORP
Street Address: 1001 E MAIN BLDG 4A
City / State / Zip Code: CARBONDALE, IL 62901
Phone Number: (618) 549-8331
Fax Number: (618) 549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 7,064	$	2,451	$ 954	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,367		2,451	320	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440		317,177	317,177	1,409	42,807	3
4	19	LEGAL AND ACCOUNTING	HOURS OF SERVICE	18,158		1,280		2,451	173	4
5	20	LICENSES AND DUES	HOURS OF SERVICE	18,158		816		2,451	110	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718		121,881	121,881	1,042	16,455	6
7	21	OFFICE SUPPLIES	HOURS OF SERVICE	18,158		18,791		2,451	2,536	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	18,158		46,167		2,451	6,232	8
9	24	SEMINARS	HOURS OF SERVICE	10,440		1,077		1,409	145	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440		8,770		1,409	1,184	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		5,657		2,451	764	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		14,736		2,451	1,989	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158		0		2,451	0	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		2,451	3,564	14
15		**Excess salary of related individual has been								15
16		eliminated prior to cost report.								16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 572,183	$ 439,058		$ 77,233	25

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FAIR ACRES NURSING HOM	X		Pay off existing constructin loan	$2,760.00	05-05-99	$ 91,089	$ 48,237	07-12-02	0.0850	$ 5,393	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,760.00		$ 91,089	$ 48,237			$ 5,393	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 91,089	$ 48,237			$ 5,393	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	14,204	2
3. Under or (over) accrual (line 2 minus line 1).	$	14,204	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	14,204	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	11,758	8
	1996	12,120	9
	1997	12,284	10
	1998	13,989	11
	1999	14,204	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,703 B. General Construction Type: Exterior MASONRY Frame MASONRY & STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING	125,722		$ 18,792	1
2					2
3	TOTALS	125,722		$ 18,792	3

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1966	1966	$ 179,381	$	40	$ 4,485	$ 4,485	$ 154,732	4
5			1966	1966	175,379		20			175,379	5
6			1987	1987	263,386		40	6,585	6,585	88,897	6
7											7
8											8
	Improvement Type**										
9	FULLY DEPRECIATED			1974	15,221					15,221	9
10	FULLY DEPRECIATED			1980	5,082					5,082	10
11	BUILDING IMPROVEMENT			1971	2,768					2,768	11
12	BUILDING IMPROVEMENT			1972	1,823					1,823	12
13	BUILDING IMPROVEMENT			1973	9,170					9,170	13
14	BUILDING IMPROVEMENT			1981	1,158		10to15			1,158	14
15	ROOF			1982	3,890		15			3,890	15
16	LAND IMPROVEMENT			1982	10,400		15			10,400	16
17	FIRE ALARM & SEAL PARKING LOT			1983	4,351		10to15			4,351	17
18	A/C ROOF TOP, WATERLINE, STORAGE BUILDING			1984	13,711		20	386	386	12,359	18
19	SEWER REPAIR			1987	1,330	89	15	89		1,201	19
20	PARKING LOT & PLUMBING			1988	14,182	77	15to25	720	643	9,000	20
21	A/C COMPRESSOR & ROOF			1989	23,834	61	15to30	825	764	8,724	21
22	ROOF REPAIR			1990	18,354		30	612	612	6,426	22
23	WATER HEATER & A/C UNITS			1990	4,675	38	15	312	274	3,275	23
24	CABINETS & NURSES STATION			1992	6,893	460	15	460		3,910	24
25	PARKING LOT SEALED AND STRIPED			1994	4,138	414	15	276	(138)	1,794	25
26	HEAT EXCHANGE ON ROOF TOP UNITS INSTALLED			1995	2,638	264	10	264		1,452	26
27	WALL A/C UNITS INSTALLED			1996	1,976		15	132	132	594	27
28	REPAIRS TO GAS LINE			1997	3,786	189	20	189		662	28
29	REPLACED CARPETING			1997	795	159	5	159		557	29
30	INSTALLED Z PTAC AIR & HEAT UNITS			1997	2,376		15	158	158	554	30
31	WATER HEATER & INSTALLATION			1998	780		10	78	78	195	31
32	ENTRANCE SIGN			1999	1,002	200	5	200		300	32
33	GAZEBO WITH RAMP AND RAILINGS			1999	3,377	169	20	169		253	33
34	LANDSCAPING			1999	978	196	5	196		294	34
35	Repairs to damaged asphalt, seal/stripe parking lot			1999	2,101	210	10	210		315	35
36	TOTAL (lines 4 thru 35)				$ 778,935	$ 2,526		$ 16,505	$ 13,979	$ 524,736	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL TILE FLOORING			2000	22,927	1,146	10	1,146		1,146	9
10	INSTALL SHOWER FAUCET REPLACEMENTS			2000	1,731	87	10	87		87	10
11	INSTALL CARPET ON WALLS			2000	4,898	490	5	490		490	11
12	WATER GARDEN			2000	922	46	10	46		46	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 30,478	$ 1,769		$ 1,769	$	$ 1,769	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 93,931	$ 264	$ 9,013	$ 8,749	various	$ 53,281	37
38	Current Year Purchases	23,857	20,539	1,659	(18,880)	various	1,659	38
39	Fully Depreciated Assets	92,564				various	92,564	39
40								40
41	TOTALS	$ 210,352	$ 20,803	$ 10,672	$ (10,131)		$ 147,504	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	JAMESTOWN ALLOCATION			$	$ 1,989	$ 1,989	$		$ 9,651	42
43										43
44										44
45										45
46	TOTALS			$	$ 1,989	$ 1,989	$		$ 9,651	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,038,557	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 27,087	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 30,935	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,848	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 683,660	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	FULLY DEPRECIATED EQUIPMEN	$ 55,632	$	$ 55,632	52
53	(no longer in use)				53
54					54
55					55
56					56
57	TOTALS	$ 55,632	$	$ 55,632	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 171 Description: storage 171
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
   We only hire trained aides.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	$	195	$ 11,348	$ 321	195	$ 11,669	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		121	8,027		121	8,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		535	27,408		535	27,408	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				16,068		16,068	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Med A & B supplies; tube feeding; Other (specify): oxygen; VA ancillaries	39/2					9,921		9,921	13
14	TOTAL			$	851	$ 46,783	$ 26,310	851	$ 73,093	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 148,370	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	330,087		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(2,515)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INCOME TAX DEPOSIT	22,800		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 498,742	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	83,611		15
16	Equipment, at Historical Cost	177,842		16
17	Accumulated Depreciation (book methods)	(210,723)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan to Twin Willows	48,236		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 98,966	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 597,708	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 53,926	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,200		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,738		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 90,864	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 90,864	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 506,844	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 597,708	$	48

***(See instructions.)**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 518,828	1
2	Restatements (describe):		2
3	1999 STATE AND FEDERAL INCOME TAXES	(22,987)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 495,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,003	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,003	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 506,844	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,792,533	1
2	Discounts and Allowances for all Levels	15,729	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,808,262	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,870	6
7	Oxygen	9,310	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 103,180	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,875	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,875	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,927,317	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	409,685	31
32	Health Care	771,141	32
33	General Administration	374,500	33
	B. Capital Expense		
34	Ownership	247,269	34
	C. Ancillary Expense		
35	Special Cost Centers	73,093	35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,916,314	40
41	**Income before Income Taxes (line 30 minus line 40)****	11,003	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 11,003	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** no **If not, please attach a reconciliation. State taxes are deducte**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,112	$ 35,944	$ 17.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,743	1,825	26,895	14.74	3
4	Licensed Practical Nurses	14,119	15,436	194,918	12.63	4
5	Nurse Aides & Orderlies	36,566	38,574	341,223	8.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,831	2,015	17,064	8.47	8
9	Activity Director	2,576	2,780	24,960	8.98	9
10	Activity Assistants					10
11	Social Service Workers	1,784	1,968	20,946	10.64	11
12	Dietician					12
13	Food Service Supervisor	1,982	2,140	19,977	9.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,945	10,727	83,005	7.74	15
16	Dishwashers					16
17	Maintenance Workers	1,959	2,078	24,393	11.74	17
18	Housekeepers	6,148	6,410	59,207	9.24	18
19	Laundry	4,112	4,547	38,243	8.41	19
20	Administrator	1,920	2,112	43,469	20.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,869	2,003	21,291	10.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) WARD CLERK	1,528	1,606	13,811	8.60	33
34	TOTAL (lines 1 - 33)	90,082	96,333	$ 965,346 *	$ 10.02	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 6,029	L1/C3	35
36	Medical Director		900	L9/C3	36
37	Medical Records Consultant		400	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		420	L10/C3	39
40	Physical Therapy Consultant	125	6,811	L10A/C3	40
41	Occupational Therapy Consultant	12	749	L10A/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	398	L10A/C3	43
44	Activity Consultant	42	2,160	L11/C3	44
45	Social Service Consultant	42	2,160	L12/C3	45
46	Other(specify) BILLING CONSULTANT		705	L19/C3	46
47	UR REVIEW		900	L10/C3	47
48	PURCHASING CONSULTANT		1,025	L19/C3	48
49	TOTAL (lines 35 - 48)	348	$ 22,657		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	3,460	56,356	L10/C3	52
53	TOTAL (lines 50 - 52)	3,460	$ 56,356		53

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RANDEE SLOVER	ADMINISTRATOR	0	$ 43,469
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,469

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
M.E.S.	PURCHASING	$ 1,025
ADP	PAYROLL	572
MIKRON	COMPUTER	1,020
BARNETT & LEVINE	ACCOUNTING	698
JAMESTOWN MGMT CORP	MANAGEMENT	135,738
Benefit Planning Consultants	401K SERVICES	400
NCS HEALTHCARE	BILLING	705
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 140,158

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,326
Unemployment Compensation Insurance	6,951
FICA Taxes	73,849
Employee Health Insurance	13,477
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	0
LIFE INSURANCE	319
VACCINES	1,596
AWARDS, INCENTIVES, PRIZES, PARTIES	14,223
401k EMPLOYER MATCHING FUNDS	5,047
JAMESTOWN ALLOCATION	6,232
TOTAL (agree to Schedule V, line 22, col.8)	$ 147,020

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,010
Health Care Worker Background Check	180
(Indicate # of checks performed 15)	
Subscriptions	296
Publice relations	1,432
Yellow page advertising	455
NAGNA	1,932
Corp fees 303; CLIA 150; Sam's Club 30	483
JAMESTOWN ALLOCATION	110
Less: Public Relations Expense	(1,432)
Non-allowable advertising	( )
Yellow page advertising	(455)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,211

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
LOCAL TRAVEL	650
Seminar Expense	1,888
JAMESTOWN ALLOCATION	145
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,683

**See instructions.

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	1994	$ 342	3	$ 57	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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18													
19													
20	TOTALS		$ 342		$ 57	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIR ACRES NURSING HOME # 0027367 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40626 LIC BED TAX**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FAIR ACRES NURSING HOME INC. #0027367
RECLASSIFICATIONS ON DPA COST REPORT 12/31/00
PAGES 3&4 COLUMN 5

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
	DESCRIPTION		
22	EMPLOYEE BENEIFITS	1867	
2	FOOD PURCHASES		1867
	RECLASSIFY EMPLOYEE MEALS		
2	FOOD PURCHASES	2760	
10	NURSING & MEDICAL RECORDS		2760
	RECLASSIFY FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	77233	
19	PROFESSIONAL SERVICES		77233
	SEE SCHVIII FOR BREAKDOWN		